

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0046193</u></p> <p>Facility Name: <u>Ridgeland Nursing & Rehab Center, Llc</u></p> <p>Address: <u>12550 South Ridgeland Avenue</u> <u>Palos Heights</u> <u>60463</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708) 597-9300</u> Fax # <u>(708) 597-2472</u></p> <p>IDPA ID Number: <u>300124873001</u></p> <p>Date of Initial License for Current Owners: <u>02/01/03</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>02/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%;"> <tr> <td style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Print Name and Title) <u>Edward N. Slack, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p style="text-align: center;">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____		(Signed) _____ (Date) _____	Paid Preparer	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																													
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc# 0046193 Report Period Beginning: 02/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>101</u>	Skilled (SNF)	<u>101</u>	<u>33,734</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>101</u>	TOTALS	<u>101</u>	<u>33,734</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,537</u>	<u>7,041</u>	<u>4,246</u>	<u>27,824</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,537</u>	<u>7,041</u>	<u>4,246</u>	<u>27,824</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 82.48%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 2/1/03

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 2/1/03 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 101 and days of care provided 4,182Medicare Intermediary Riverbend Government Benefits Administrator

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc # 0046193 Report Period Beginning: 02/01/03 Ending: 12/31/03**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	199,146	23,848	8,715	231,709		231,709	(1,527)	230,182		1
2	Food Purchase		118,005		118,005		118,005	1,045	119,050		2
3	Housekeeping	95,991	26,052		122,043		122,043	(3,095)	118,948		3
4	Laundry	45,232	52,846		98,078		98,078	(5,806)	92,272		4
5	Heat and Other Utilities			75,295	75,295		75,295	729	76,024		5
6	Maintenance	73,606		77,810	151,416		151,416	(5,863)	145,553		6
7	Other (specify):*							2,493	2,493		7
8	TOTAL General Services	413,975	220,751	161,820	796,546		796,546	(12,025)	784,521		8
	B. Health Care and Programs										
9	Medical Director			16,625	16,625		16,625		16,625		9
10	Nursing and Medical Records	1,531,333	30,472	26,481	1,588,286		1,588,286	(6,400)	1,581,886		10
10a	Therapy	64,535	7,509	400	72,444		72,444	247	72,691		10a
11	Activities	58,863	9,951	2,304	71,118		71,118	13	71,131		11
12	Social Services	68,995		4,203	73,198		73,198	8,288	81,486		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*							2,629	2,629		15
16	TOTAL Health Care and Programs	1,723,726	47,932	50,013	1,821,671		1,821,671	4,777	1,826,448		16
	C. General Administration										
17	Administrative	65,229			65,229		65,229	5,354	70,583		17
18	Directors Fees										18
19	Professional Services			121,715	121,715		121,715	(77,566)	44,149		19
20	Dues, Fees, Subscriptions & Promotions			25,945	25,945		25,945	(9,956)	15,989		20
21	Clerical & General Office Expenses	76,868	22,442	67,031	166,341		166,341	21,547	187,888		21
22	Employee Benefits & Payroll Taxes			378,662	378,662		378,662	(6,547)	372,115		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,066	3,066		3,066	462	3,528		24
25	Other Admin. Staff Transportation			1,800	1,800		1,800		1,800		25
26	Insurance-Prop.Liab.Malpractice			82,143	82,143		82,143	603	82,746		26
27	Other (specify):*							8,368	8,368		27
28	TOTAL General Administration	142,097	22,442	680,362	844,901		844,901	(57,735)	787,166		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,279,798	291,125	892,195	3,463,118		3,463,118	(64,983)	3,398,135		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc #0046193 Report Period Beginning: 02/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			14,955	14,955		14,955	39,819	54,774			30
31	Amortization of Pre-Op. & Org.			8,702	8,702		8,702	1,406	10,108			31
32	Interest			20,981	20,981		20,981	110,370	131,351			32
33	Real Estate Taxes			160,537	160,537		160,537	(11,406)	149,131			33
34	Rent-Facility & Grounds			270,342	270,342		270,342	(268,550)	1,792			34
35	Rent-Equipment & Vehicles			819	819		819	870	1,689			35
36	Other (specify):*											36
37	TOTAL Ownership			476,336	476,336		476,336	(127,491)	348,845			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		245,132	229,402	474,534		474,534	(4,884)	469,650			39
40	Barber and Beauty Shops			14,756	14,756		14,756	(14,756)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,601	50,601		50,601		50,601			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		245,132	294,759	539,891		539,891	(19,640)	520,251			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,279,798	536,257	1,663,290	4,479,345		4,479,345	(212,113)	4,267,232			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc

0046193

Report Period Beginning: 02/01/03

Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(11,358)	30		9
10	Interest and Other Investment Income	(27)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(294)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(30)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,400)	21		24
25	Fund Raising, Advertising and Promotional	(10,489)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(52,421)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (112,018)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(100,095)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (100,095)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (212,113)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
Ridgeland Nursing & Rehab Center, LLC			
ID# 0044193			
Report Period Beginning:	02/01/03		
Ending:	12/31/03		
NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1			1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
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98			98
99			99
100			100
101	Total	(52,423)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc# 0046193

Report Period Beginning:

02/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			24		1,591	(2,304)		(838)				(1,527)	1
2	Food Purchase	(294)		(43)			1,382						1,045	2
3	Housekeeping					457			(3,552)				(3,095)	3
4	Laundry								(5,806)				(5,806)	4
5	Heat and Other Utilities			729									729	5
6	Maintenance	(4,764)		761	(3,535)	1,673	2						(5,863)	6
7	Other (specify):*				1,976	461	56						2,493	7
8	TOTAL General Services	(5,058)		1,471	(1,559)	4,182	(864)		(10,197)				(12,025)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,072)		97	(7,793)	5,282			(2,914)				(6,400)	10
10a	Therapy					247							247	10a
11	Activities			13									13	11
12	Social Services				8,215	73							8,288	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				1,947	682							2,629	15
16	TOTAL Health Care and Programs	(1,072)		110	2,369	6,284			(2,914)				4,777	16
	C. General Administration													
17	Administrative					5,314	40						5,354	17
18	Directors Fees													18
19	Professional Services	(256)		(77,323)			13						(77,566)	19
20	Fees, Subscriptions & Promotions	(10,519)		559			4						(9,956)	20
21	Clerical & General Office Expenses	(40,217)	855	8,106		52,717	86						21,547	21
22	Employee Benefits & Payroll Taxes				(5,926)			(621)					(6,547)	22
23	Inservice Training & Education													23
24	Travel and Seminar			351			111						462	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			603									603	26
27	Other (specify):*				1,198	7,170							8,368	27
28	TOTAL General Administration	(50,992)	855	(67,704)	(4,728)	65,201	254	(621)					(57,735)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(57,122)	855	(66,123)	(3,918)	75,667	(610)	(621)	(13,111)				(64,983)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc # 0046193 Report Period Beginning: 02/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(11,358)	47,296	3,881									39,819	30
31	Amortization of Pre-Op. & Org.	(28,756)	30,162										1,406	31
32	Interest	(27)	102,757	7,639			1						110,370	32
33	Real Estate Taxes		(12,489)	1,083									(11,406)	33
34	Rent-Facility & Grounds		(270,342)	1,792									(268,550)	34
35	Rent-Equipment & Vehicles			848			22						870	35
36	Other (specify):*													36
37	TOTAL Ownership	(40,141)	(102,616)	15,243			23						(127,491)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(208)		(4,676)				(4,884)	39
40	Barber and Beauty Shops	(14,756)											(14,756)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(14,756)					(208)		(4,676)				(19,640)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(112,018)	(101,761)	(50,880)	(3,918)	75,667	(795)	(621)	(17,787)				(212,113)	45

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc# 0046193

Report Period Beginning:

02/01/03

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Ridgeland Property LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 270,342	Ridgeland Property LLC		\$ 148,048	\$ (270,342)	1
2	V	33 Real Estate Tax	160,537			148,048	(12,489)	2
3	V	32 Interest				102,757	102,757	3
4	V	21 Bank Charges				855	855	4
5	V	30 Depreciation				47,296	47,296	5
6	V	31 Amortization				30,162	30,162	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 430,879			\$ 329,118	\$ * (101,761)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc# 0046193Report Period Beginning: 02/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$	Care Centers, Inc.	100.00%	\$ 24	\$ 24
16	V	05 Utilities		Care Centers, Inc.	100.00%	729	729
17	V	06 Maintenance		Care Centers, Inc.	100.00%	761	761
18	V	10 Nursing	14	Care Centers, Inc.	100.00%	111	97
19	V	11 Activities		Care Centers, Inc.	100.00%	13	13
20	V	19 Professional Fees	82,196	Care Centers, Inc.	100.00%	4,873	(77,323)
21	V	20 Dues and Subscriptions		Care Centers, Inc.	100.00%	559	559
22	V	21 Office & Clerical		Care Centers, Inc.	100.00%	8,106	8,106
23	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	351	351
24	V	26 Insurance		Care Centers, Inc.	100.00%	603	603
25	V	30 Depreciation		Care Centers, Inc.	100.00%	3,881	3,881
26	V	32 Interest		Care Centers, Inc.	100.00%	7,639	7,639
27	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	1,083	1,083
28	V	34 Rent - Building		Care Centers, Inc.	100.00%	1,792	1,792
29	V	35 Rent - Equipment and Auto		Care Centers, Inc.	100.00%	848	848
30	V	25 Bus Reimbursement		Care Centers, Inc.	100.00%		
31	V	02 Food	43	Care Centers, Inc.	100.00%		(43)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 82,253			\$ 31,373	\$ * (50,880)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, LLC# 0046193Report Period Beginning: 02/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance Salary	\$ 18,962	Care Centers, Inc.	100.00%	\$ 15,427	\$ (3,535)	15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,976	1,976	16
17	V	10 Nursing Salary	11,526	Care Centers, Inc.	100.00%	3,733	(7,793)	17
18	V	10a Rehab Salary		Care Centers, Inc.	100.00%			18
19	V	11 Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12 Social Service Salary	3,879	Care Centers, Inc.	100.00%	12,094	8,215	20
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,947	1,947	21
22	V	17 Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21 Office Salary	8,709	Care Centers, Inc.	100.00%	8,709		23
24	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	1,198	1,198	24
25	V	22 Employee Benefits	5,926	Care Centers, Inc.	100.00%		(5,926)	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 49,002			\$ 45,084	\$ * (3,918)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc# 0046193Report Period Beginning: 02/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary Salary	\$	Care Centers, Inc.	100.00%	\$ 1,591	\$ 1,591	15
16	V	03 Housekeeping Salary		Care Centers, Inc.	100.00%	457	457	16
17	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	1,673	1,673	17
18	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	461	461	18
19	V	10 Nursing Salary		Care Centers, Inc.	100.00%	5,282	5,282	19
20	V	10a Rehab Salary		Care Centers, Inc.	100.00%	247	247	20
21	V	12 Social Services Salary		Care Centers, Inc.	100.00%	73	73	21
22	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	682	682	22
23	V	17 Administration Salary		Care Centers, Inc.	100.00%	5,314	5,314	23
24	V	21 Office Salary		Care Centers, Inc.	100.00%	52,717	52,717	24
25	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	7,170	7,170	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 75,667	\$ * 75,667	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, LLC# 0046193Report Period Beginning: 02/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$ 2,962	Care Centers, Inc. - Health Systems Division	100.00%	\$ 224	\$ (2,738)
16	V	02 Food		Care Centers, Inc. - Health Systems Division	100.00%	1,382	1,382
17	V	06 Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	2	2
18	V	17 Administration		Care Centers, Inc. - Health Systems Division	100.00%	40	40
19	V	19 Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	13	13
20	V	20 Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	4	4
21	V	21 Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	86	86
22	V	24 Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	111	111
23	V	32 Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	1	1
24	V	35 Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	22	22
25	V	39 Ancillary Enteral Supplies	390	Care Centers, Inc. - Health Systems Division	100.00%	182	(208)
26	V	01 Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	434	434
27	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	56	56
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 3,352			\$ 2,557	\$ * (795)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc# 0046193Report Period Beginning: 02/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 147,403	\$ 147,403	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	148,024	CCS EMPLOYEE BENEFIT GROUP	100.00%		(148,024)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 148,024			\$ 147,403	\$ * (621)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc# 0046193Report Period Beginning: 02/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 DIETARY	\$ 6,370	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 5,531	\$ (838)
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%		
17	V	03 HOUSEKEEPING	26,987	XCEL MEDICAL SUPPLY, LLC	100.00%	23,435	(3,552)
18	V	04 LAUNDRY	44,112	XCEL MEDICAL SUPPLY, LLC	100.00%	38,306	(5,806)
19	V	06 REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%		
20	V	10 NURSING	22,141	XCEL MEDICAL SUPPLY, LLC	100.00%	19,226	(2,914)
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%		
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
24	V	22 EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%		
25	V	39 ANCILLARY	35,522	XCEL MEDICAL SUPPLY, LLC	100.00%	30,846	(4,676)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 135,131			\$ 117,344	\$ * (17,787)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc# 0046193Report Period Beginning: 02/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc# 0046193Report Period Beginning: 02/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc# 0046193Report Period Beginning: 02/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc # 0046193 Report Period Beginning: 02/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	1.00%	See Attached	0.59	1.07%		\$		1
2	Adam Vales	Owner	Clerical	11.00%	See Attached	0.76	1.90%	CCS-VEBA	590	22-7	2
3	Mark Steinberg	Relative	Administrative	0	See Attached	0.93	1.84%	CCI salary	737	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,327		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc # 0046193 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc # 0046193 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary	Patient Days	1,764,895	42	\$ 1,527	\$	27,824	\$ 24	1
2	05 Utilities	Patient Days	1,764,895	42	46,229		27,824	729	2
3	06 Maintenance	Patient Days	1,764,895	42	48,251		27,824	761	3
4	10 Nursing	Patient Days	1,764,895	42	7,018		27,824	111	4
5	11 Activities	Patient Days	1,764,895	42	838		27,824	13	5
6	19 Professional Fees	Patient Days	1,764,895	42	309,074		27,824	4,873	6
7	20 Dues and Subscriptions	Patient Days	1,764,895	42	35,428		27,824	559	7
8	21 Office & Clerical	Patient Days	1,764,895	42	523,091		27,824	8,106	8
9	24 Travel and Seminar	Patient Days	1,764,895	42	22,233		27,824	351	9
10	26 Insurance	Patient Days	1,764,895	42	38,230		27,824	603	10
11	30 Depreciation	Patient Days	1,764,895	42	246,194		27,824	3,881	11
12	32 Interest	Patient Days	1,764,895	42	484,531		27,824	7,639	12
13	33 Real Estate Taxes	Patient Days	1,764,895	42	68,681		27,824	1,083	13
14	34 Rent - Building	Patient Days	1,764,895	42	113,677		27,824	1,792	14
15	35 Rent - Equipment & Auto	Patient Days	1,764,895	42	53,777		27,824	848	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,998,780	\$		\$ 31,373	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc # 0046193 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06 Maintenance Salary	Direct Cost			213,393	213,393		15,427	1
2	07 Emp. Ben. - Gen. Serv.	Direct Cost			26,918			1,976	2
3	10 Nursing Salary	Direct Cost			976,718	976,718		3,733	3
4	10a Rehab Salary	Direct Cost			103,898	103,898			4
5	11 Activity Salary	Direct Cost			10,902	10,902			5
6	12 Social Service Salary	Direct Cost			306,863	306,863		12,094	6
7	15 Emp. Ben. - Healthcare	Direct Cost			174,348			1,947	7
8	17 Administration Salary	Direct Cost			1,191,200	1,191,200			8
9	21 Office Salary	Direct Cost			698,886	698,886		8,709	9
10	27 Emp. Ben. - Gen. Admin.	Direct Cost			238,998			1,198	10
11	22 Employee Benefits								11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,942,124	\$ 3,501,860		\$ 45,084	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc # 0046193 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary Salary	Patient Days	1,764,895	42	100,923	100,923	27,824	1,591	1
2	03 Housekeeping Salary	Patient Days	1,764,895	42	28,979	28,979	27,824	457	2
3	06 Maintenance Salary	Patient Days	1,764,895	42	106,088	106,088	27,824	1,673	3
4	07 Emp. Ben. - Gen. Serv.	Patient Days	1,764,895	42	29,264		27,824	461	4
5	10 Nursing Salary	Patient Days	1,764,895	42	335,028	335,028	27,824	5,282	5
6	10a Rehab Salary	Patient Days	1,764,895	42	15,649	15,649	27,824	247	6
7	12 Social Services Salary	Patient Days	1,764,895	42	4,661	4,661	27,824	73	7
8	15 Emp. Ben. - Healthcare	Patient Days	1,764,895	42	43,235		27,824	682	8
9	17 Administration Salary	Patient Days	1,764,895	42	337,043	337,043	27,824	5,314	9
10	21 Office Salary	Patient Days	1,764,895	42	3,343,864	3,343,864	27,824	52,717	10
11	27 Emp. Ben. - Gen. Admin.	Patient Days	1,764,895	42	454,813		27,824	7,170	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,799,547	\$ 4,272,235		\$ 75,667	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc # 0046193 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary	Billable Income	2,073,579		138,556		3,352	224	1
2	02 Food	Billable Income	2,073,579		852,614		3,352	1,382	2
3	06 Maintenance	Billable Income	2,073,579		1,311		3,352	2	3
4	17 Administration	Billable Income	2,073,579		25,000		3,352	40	4
5	19 Professional Fees	Billable Income	2,073,579		8,170		3,352	13	5
6	20 Dues & Subscriptions	Billable Income	2,073,579		2,312		3,352	4	6
7	21 Office & Clerical	Billable Income	2,073,579		53,285		3,352	86	7
8	24 Travel & Seminar	Billable Income	2,073,579		68,680		3,352	111	8
9	32 Interest Expense	Billable Income	2,073,579		571		3,352	1	9
10	35 Rent - Equipment & Auto	Billable Income	2,073,579		13,336		3,352	22	10
11	39 Ancillary Enteral Supplies	Billable Income	2,073,579		114,955		3,352	182	11
12	01 Dietary - Salary	Billable Income	2,073,579		268,554	268,554	3,352	434	12
13	07 Emp. Ben. - Gen. Serv.	Billable Income	2,073,579		34,942		3,352	56	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,582,287	\$ 268,554		\$ 2,557	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc # 0046193 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 4101 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847)905-4000
 Fax Number (847)905-4040

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 147,403	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 147,403	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, LLC # 0046193 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization XCEL MEDICAL SUPPLY, LLC
 Street Address 2201 MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 DIETARY	Direct Allocation			\$	\$		\$ 5,531	1
2	02 FOOD	Direct Allocation							2
3	03 HOUSEKEEPING	Direct Allocation						23,435	3
4	04 LAUNDRY	Direct Allocation						38,306	4
5	06 REPAIRS & MAINTENANCE	Direct Allocation							5
6	10 NURSING	Direct Allocation						19,226	6
7	10A THERAPY	Direct Allocation							7
8	12 SOCIAL SERVICE	Direct Allocation							8
9	21 CLERICAL & GENERAL OFFICE	Direct Allocation							9
10	22 EMPLOYEE BENEFITS	Direct Allocation							10
11	39 ANCILLARY	Direct Allocation						30,846	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 117,344	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc # 0046193 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc # 0046193 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeland Nursing & Rehab Center, Llc # 0046193 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	LaSalle Bank		X	Mortgage			\$	\$	1,800,392			\$	102,757	1
2														2
3														3
4														4
5	See Supplemental Schedule													5
	Working Capital													
6	LaSalle Bank		X	Line of Credit					733,082				20,981	6
7	Alloc from Care Centers		X										7,640	7
8	See Supplemental Schedule								198,430					8
9	TOTAL Facility Related						\$	\$	2,731,904			\$	131,378	9
	B. Non-Facility Related*													
10														10
11	Interest Income												(27)	11
12														12
13	See Supplemental Schedule													13
14	TOTAL Non-Facility Related						\$	\$				\$	(27)	14
15	TOTALS (line 9+line14)						\$	\$	2,731,904			\$	131,351	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	Genesis (prior owner)		X				\$	\$ 125,483			\$	8	
9	Shareholder	X						72,947				9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital							198,430				14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

- * Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- ** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Ridgeland Nursing & Rehab Center, Llc**# **0046193** Report Period Beginning: **02/01/03** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	(11,406) 2
3. Under or (over) accrual (line 2 minus line 1).		\$	(11,406) 3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	160,537 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	149,131 7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998	109,538	8
	1999	132,539	9
	2000	136,078	10
	2001	117,661	11
	2002	152,892	12
2003 Accrual = 2002 Tax \$152,892 x 1.05 = \$160,537		13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
Care Centers (Allocation) = \$1,083		14	PLUS APPEAL COST FROM LINE 5 \$ 14
The credit on line 2 represents a credit from the prior owners for January 03 of \$12,489 less CCI allocation of \$1,083		15	LESS REFUND FROM LINE 6 \$ 15
		16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ridgeland Nursing & Rehab Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046193

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>68,681.49</u>	\$ <u>1,082.78</u>
2. <u>24-30-404-033-0000</u>	<u>Long Term Care Property</u>	\$ <u>152,891.85</u>	\$ <u>152,891.85</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>221,573.34</u>	\$ <u>153,974.63</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ridgeland Nursing & Rehab Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046193

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
 24,446

B. General Construction Type:
 Exterior
 Frame
 Number of Stories
 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☒ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:
 54,025

2. Number of Years Over Which it is Being Amortized:
 Various

3. Current Period Amortization:
 10,108

4. Dates Incurred:
 2003

Nature of Costs:
 Organization Costs (8702), Loan Cost (927), Settlement (478)

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	139,860	2003	\$ 174,831	1
2	2201 Main LLC allocation			8,015	2
3	TOTALS	139,860		\$ 182,846	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10								-		-	9
11								-		-	10
12								-		-	11
13								-		-	12
14								-		-	13
15								-		-	14
16								-		-	15
17								-		-	16
18								-		-	17
19								-		-	18
20								-		-	19
21								-		-	20
22								-		-	21
23								-		-	22
24								-		-	23
25								-		-	24
26								-		-	25
27								-		-	26
28								-		-	27
29								-		-	28
30								-		-	29
31								-		-	30
32								-		-	31
33								-		-	32
34								-		-	33
35								-		-	34
36								-		-	35

*Total beds on this schedule must agree with page 2.
 See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.
 SEE ACCOUNTANTS' COMPILATION REPORT

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		1,528,095	35,019		35,019		35,019	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		30,317	1,013		1,013		1,079	68
69	Financial Statement Depreciation			11,814			(11,814)		69
70	TOTAL (lines 4 thru 69)		\$ 1,558,412	\$ 47,846		\$ 36,032	\$ (11,814)	\$ 36,098	70

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,558,412	\$ 47,846		\$ 36,032	\$ (11,814)	\$ 36,098	1
2	Painting	2003	1,791		20	75	75	75	2
3	Painting	2003	788		20	33	33	33	3
4	Painting	2003	3,483		20	145	145	145	4
5	Resident Room Wallcoverings	2003	7,660		20	287	287	287	5
6	Pothole Patches	2003	550		20	18	18	18	6
7	Electrical Work	2003	2,205		20	74	74	74	7
8	Electrical Work	2003	2,205		20	64	64	64	8
9	2 Door Holders	2003	2,296		20	67	67	67	9
10	Clear Glass Doorlites	2003	890		20	26	26	26	10
11	Paint	2003	1,032		20	26	26	26	11
12	Install Trane Stats	2003	2,429		20	61	61	61	12
13	Control Panel Repair	2003	632		20	16	16	16	13
14	Full Lighting Upgrade Work	2003	10,325		20	86	86	86	14
15	New Keypads Installation	2003	5,597		20	47	47	47	15
16	Painting	2003	658		20	27	27	27	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward	\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	34

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward	\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	34

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward	\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	34

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward	\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	34

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward	\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	34

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,600,953	\$ 47,846		\$ 37,084	\$ (10,762)	\$ 37,150	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		2003	1985	\$ 1,528,095	\$ 35,019		\$ 35,019	\$	\$ 35,019	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,528,095	\$ 35,019		\$ 35,019	\$	\$ 35,019	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)	\$ 30,317	\$ 1,013		\$ 1,013	\$	\$ 1,079		70

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 20,580	\$ 1,494	\$ 1,494	\$	10	\$ 17,016	71
72	Current Year Purchases	167,873	15,551	14,955	(596)	10	14,955	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 188,453	\$ 17,045	\$ 16,449	\$ (596)		\$ 31,971	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Centers allocation			\$ 10,620	\$ 1,155	\$ 1,155	\$	5	\$ 1,155	76
77	Care Centers allocation			865	86	86		5	86	77
78										78
79										79
80	TOTALS			\$ 11,485	\$ 1,241	\$ 1,241	\$		\$ 1,241	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,983,737	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 66,132	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 54,774	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (11,358)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 70,362	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation from Care Center				1,792			5
6								6
7	TOTAL				\$ 1,792			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 1,689

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ _____

13. /2005 \$ _____

14. /2006 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 42,515	\$		\$ 42,515	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			8,363			8,363	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			178,524			178,524	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				176,480		176,480	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						68,652		68,652	13
14	TOTAL			\$		\$ 229,402	\$ 245,132		\$ 474,534	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 14,586	\$ 34,467	1
2	Cash-Patient Deposits	11,566	11,566	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	819,464	819,464	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,148	24,148	6
7	Other Prepaid Expenses	10,482	10,482	7
8	Accounts Receivable (owners or related parties)	253,108	(7,372)	8
9	Other(specify): See Attached Schedule	48,200	113,419	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,181,554	\$ 1,006,174	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		174,831	13
14	Buildings, at Historical Cost		1,528,095	14
15	Leasehold Improvements, at Historical Cost	30,380	30,380	15
16	Equipment, at Historical Cost	37,098	171,027	16
17	Accumulated Depreciation (book methods)	(14,955)	(14,955)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		500,900	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	290	15,958	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 52,813	\$ 2,406,236	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,234,367	\$ 3,412,410	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 296,460	\$ 296,461	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,366	11,366	28
29	Short-Term Notes Payable	733,082	931,512	29
30	Accrued Salaries Payable	180,821	180,821	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,953	11,953	31
32	Accrued Real Estate Taxes(Sch.IX-B)	160,537	160,537	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	42,040	42,040	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,436,259	\$ 1,634,690	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,800,392	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,800,392	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,436,259	\$ 3,435,082	46
47	TOTAL EQUITY(page 18, line 24)	\$ (201,892)	\$ (22,672)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,234,367	\$ 3,412,410	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(201,892)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (201,892)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (201,892)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,136,221	1
2	Discounts and Allowances for all Levels	(1,198,861)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,937,360	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,002,566	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,002,566	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	17,141	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	174,624	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,910	19
20	Radiology and X-Ray	6,250	20
21	Other Medical Services	112,659	21
22	Laundry	2,899	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 337,483	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	27	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	17	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,277,453	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	796,546	31
32	Health Care	1,821,671	32
33	General Administration	844,901	33
	B. Capital Expense		
34	Ownership	476,336	34
	C. Ancillary Expense		
35	Special Cost Centers	489,290	35
36	Provider Participation Fee	50,601	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,479,345	40
41	Income before Income Taxes (line 30 minus line 40)**	(201,892)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (201,892)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Ridgeland Nursing & Rehab Center, Llc**# **0046193**Report Period Beginning: **02/01/03**Ending: **12/31/03**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,707	1,904	\$ 60,903	\$ 31.99	1
2	Assistant Director of Nursing	1,624	1,801	46,965	26.08	2
3	Registered Nurses	9,881	11,131	269,579	24.22	3
4	Licensed Practical Nurses	20,223	22,669	465,084	20.52	4
5	Nurse Aides & Orderlies	56,663	62,574	666,258	10.65	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,810	4,303	64,535	15.00	8
9	Activity Director	1,836	2,202	28,068	12.75	9
10	Activity Assistants	3,257	3,539	30,795	8.70	10
11	Social Service Workers	3,917	4,382	68,995	15.75	11
12	Dietician					12
13	Food Service Supervisor	1,759	1,904	39,125	20.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,205	14,730	160,021	10.86	15
16	Dishwashers					16
17	Maintenance Workers	4,270	4,693	73,606	15.68	17
18	Housekeepers	11,866	12,925	95,991	7.43	18
19	Laundry	5,349	5,843	45,232	7.74	19
20	Administrator	1,769	1,819	65,229	35.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,439	7,101	76,868	10.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,760	1,947	22,544	11.58	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	149,335	165,467	\$ 2,279,798 *	\$ 13.78	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	190	\$ 8,590	01-03	35
36	Medical Director	monthly	16,625	09-03	36
37	Medical Records Consultant	monthly	3,541	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	4,121	10-03	39
40	Physical Therapy Consultant	8	400	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,304	11-03	44
45	Social Service Consultant	6	324	12-03	45
46	Other(specify)				46
47	<u>Passover Consultant</u>		125	01-03	47
48	<u>CCI - see attached</u>		15,405		48
49	TOTAL (lines 35 - 48)	252	\$ 51,435		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	55	\$ 2,714	10-03	50
51	Licensed Practical Nurses	132	4,579	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	187	\$ 7,293		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes	F. Dues, Fees, Subscriptions and Promotions
Name	Function	% Ownership	Amount	Description	Amount
Patrick DiPaolo	Administrator	0	\$ 65,229	Workers' Compensation Insurance	\$ 95,929
				Unemployment Compensation Insurance	33,095
				FICA Taxes	161,426
				Employee Health Insurance	74,898
				Employee Meals	
				Illinois Municipal Retirement Fund (IMRF)*	
				Christmas Expense	1,749
				Misc. Employee Welfare	5,018
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 65,229		
(List each licensed administrator separately.)					
B. Administrative - Other					
Description			Amount		
			\$		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V,	\$ 372,115
(Attach a copy of any management service agreement)				line 22, col.8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees	
Vendor/Payee	Type		Amount	Description	Line # Amount
Frost, Ruttenberg & Rothblatt	Accounting	\$	16,500		
Care Centers Inc.	Home Office Expense		66,660		
CT Corporation	Legal (adjusted page5)		256		
Mayer Magence	Legal		500		
Care Centers Inc.	Bookkeeping Services		13,736		
Ivans	Data Processing		158		
National Datacare	Data Processing		1,040		
Keane Care	Data Processing		9,424		
ADP, Inc.	Payroll Processing		4,916		
Sitebuilders	Data Processing		11		
Achieve Healthcare	Data Processing		2,450		
See Supplemental Schedule			6,064		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 121,715	TOTAL	\$
(If total legal fees exceed \$2500 attach copy of invoices.)					
				G. Schedule of Travel and Seminar**	
				Description	Amount
				Out-of-State Travel	\$
				In-State Travel	
				Seminar Expense	1,520
				Educational Expense	1,546
				Allocation from Care Centers	462
				Entertainment Expense	(
				(agree to Sch. V,	
				line 24, col. 8)	\$ 3,528

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,055 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 50,601
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT